Mitral Valve Prolapse Questionnaire

Name: ______________________________ Date of Birth: _________________________
Height: __________ Weight: ___________ Sex: M/ F
Tobacco Usage: ______________________ Face Amount: ________________________
State of Residence: ___________________________
___Term 10 15 20 30 ___UL

1. When was the proposed insured diagnosed with Mitral Valve Prolapse?
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2. Has the proposed insured had any of the following symptoms? (Check all that apply)
___Shortness of Breath __Chest pain ___Heart Palpitations
___Low Body Weight ___ Low Blood pressure ___Mitral Valve Regurgitation
___Heart failure

3. Has surgery been done or is it expected for this condition? ___Yes ___No
(If yes, please provide details and dates): ____
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4. Have any of the following tests been completed?
___Thallium Stress ECG Date: _________________
Results: ____
___Echocardiogram Date: _________________
Results: ____
___Angiography Date: _________________
Results: ____
___Stress Echocardiogram Date: _________________
Results: ____
___Chest X-ray Date: _________________
Results: ____
___Other ___________ Date: _________________
Results: ____

5. Is, the proposed insured, taking any medication for this condition, or any other? ____Yes ____No
(If yes, please provide name, dosage, and frequency)
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